MARKET CONDUCT EXAMINATION

GROUP HEALTH COOPERATIVE
GROUP HEALTH OPTIONS, INC.

521 WALL STREET
SEATTLE, WASHINGTON 98121

January 1, 2003 – March 31, 2004

Exhibit A
Order No. G 05-85

TABLE OF CONTENTS

The Honorable Mike Kreidler
Washington State Insurance Commissioner
302 14th Avenue SW
P.O. Box 40258
Olympia, Washington 98504-0258

Dear Commissioner Kreidler:

Pursuant to your instructions and in compliance with the statutory requirements of RCW 48.44.145 and RCW 48.46.120 and procedures promulgated by the National Association of Insurance Commissioners and the Office of the Insurance Commissioner (OIC), an examination of the market conduct affairs has been performed of:

Group Health Cooperative, NAIC #95672
Group Health Options, Inc., NAIC #47055
521 Wall Street
Seattle, Washington 98121

In this report, Group Health Cooperative is referred to as GHC. Group Health Options, Inc. is referred to as GHO. Collectively these entities are referred to as the Companies.

This report of examination is respectfully submitted.

CHIEF EXAMINER'S REPORT CERTIFICATION and ACKNOWLEDGEMENTS

This examination was conducted in accordance with Office of Insurance Commissioner and National Association of Insurance Commissioners market conduct examination procedures. Nancy L. Barnes, AIE, ACS; George J. Lazur, CIE, CPCU; Sandy Ray, CPCU and Charlotte F. Wright of the Washington State Office of Insurance Commissioner performed this examination and participated in the preparation of this report.

The examiners wish to express appreciation for the courtesy and cooperation extended by the personnel of Group Health Cooperative and Group Health Options, Inc. during the course of this market conduct examination.

I certify that this document is the report of the examination, that I have reviewed this report in conjunction with pertinent examination work papers, that this report meets the provisions for such reports prescribed by the Office of Insurance Commissioner and that this report is true and correct to the best of my knowledge and belief.

Leslie A. Krier, AIE, FLMI
Chief Market Conduct Examiner
Office of the Insurance Commissioner
State of Washington

FOREWORD

This examination was completed by applying tests to each examination standard. Each test applied during the examination is stated in this report and the results are reported. Exceptions are noted as part of the comments for the applied test. Throughout the report, where cited, RCW refers to the Revised Code of Washington, and WAC refers to Washington Administrative Code.

Scope

Time Frame

The examination covered the Companies' operations from January 1, 2003 through March 31, 2004. There was a prior examination in 1995 of Group Health Cooperative. There was a prior examination in 1993 of Group Health Options, Inc. This examination was performed both in the Seattle OIC office and on-site at the Companies' office in Tukwila, Washington.

Matters Examined

The examination included a review of the following areas:

Advertising	Agent Activity
Claims	Complaints
Rate and Form Filing	Provider Activity
Underwriting and Policy Administration	Network Adequacy

Sampling Standards

Methodology

In general, the sample for each test utilized in this examination falls within the following guidelines:

92 %	Confidence Level
+/- 5 %	Mathematical Tolerance.

Regulatory Standards

Market conduct samples are tested for compliance with standards established by the OIC. The tests applied to sampled data will result in an error ratio, which determines whether or not a standard is met. If the error ratio found in the sample is, generally, less than 5%, the standard will be considered as met. The standards in the area of agent licensing and appointment, and

policy and form filings will not be met if any violation is identified. This will also apply when all records are examined, in lieu of a sample.

For those standards, which look for the existence of written procedures, or a process to be in place, the standard will be met based on the examiner's analysis of those procedures or processes. The analysis will include a determination of whether or not the company follows established procedures.

Standards will be reported as Passed (without Comment), Passed with Comment or Failed. The definition of each category follows:

Passed	There were no findings for the standard.
Passed with Comment	Errors in the records reviewed fell within the tolerance level for that standard.
Failed	Errors in the records reviewed fell outside of the tolerance level established for the standard.

COMPANY OPERATIONS AND MANAGEMENT

Company History

Group Health Cooperative of Puget Sound (GHC) was incorporated in 1945. The Office of Insurance Commissioner issued a certificate of registration to GHC on April 7, 1976. It is a not-for-profit health maintenance organization (HMO).

In 1997, GHC and Kaiser Permanente affiliated to market to regional and national customers, sharing best clinical practices, and full-service member reciprocity. Each organization retains its independence, assets, and separate governance systems.

On December 31, 1999, all assets and liability of GHC's former affiliate, Group Health Northwest, which was based in Spokane, Washington, were transferred to GHC.

Group Health Cooperative officially eliminated the words "of Puget Sound" from its name on December 31, 2002.

Group Health Cooperative created a wholly owned subsidiary, Options Health Care, Incorporated in 1990. Options Heath Care was issued a certificate of registration as a health care service contractor (HCSC) on October 23, 1990. Through an administrative services agreement between GHC and Options Health Care, GHC contracted to provide a wide range of administrative support services to Options Health Care. Additionally, the parties entered into a medical services agreement through which GHC provided or arranged medical services to enrollees of Options Health Care on a capitated basis.

In April 1994, GHC and Virginia Mason, which was registered as an HCSC on September 1, 1983, established Virginia Mason-Group Health Alliance, Inc. (Alliance) to develop new joint managed care products. GHC became sole owner of Virginia Mason-Group Health Alliance, Inc. in July of 1997. Options Health Care and Alliance began operating under a single management structure. Effective December 31, 2000, Virginia Mason-Group Health Alliance, Inc. merged into Options Health Care, Inc, which was renamed Group Health Options, Incorporated. In 2002, the administrative services agreement between Virginia Mason and Group Health Options ended. Administrative tasks previously handled by Virginia Mason, such as claims, referral services medical management, and pharmacy help desk were transferred to GHC.

In December 2002, Group Health Options, Incorporated underwent a name change to Group Health Options, Inc.

Company Management & Operations

GHC members age 18 and over are eligible to be voting members. Members must complete a form to register to vote. When enrolling, members are notified about their eligibility and are given instructions about procedure for registering as a voting member. Voting members elect the 11-member Board of Trustees and decide bylaws and policy-related advisory referenda. Trustee elections are held annually, as part of the annual membership meeting, per the GHC bylaws. Mail ballots are sent out to eligible voting members approximately one month prior to the annual meeting with a ballot deadline of three (3) days before the meeting date. Those members who have not voted by mail ballot have the opportunity to vote the day of the annual meeting before the business meeting starts. The GHC Board typically meets in executive session ten (10) times annually: February, March, April, May, June, July, September, October, November, and December. The GHC Board meets in public session four (4) times annually: February, April, July, and September.

The current members of the Board of Trustees are:

Board Member/Position	Company/Community Affiliation	Original Appointment Date	Term Expires
Ruth Ballweg, Chair	University of Washington	1/1/99	12/31/05
Bobbie Berkowitz	University of Washington	1/1/00	12/31/06
Jerry Campbell, Vice Chair	Retired	1/1/00	12/31/07
Ann Daley	Evergreen State College	1/1/00	12/31/06
Rosemary Daskiewicz	Cairncross & Hempelmann	1/1/02	12/31/06
Aubrey Davis, Former President and CEO of Group Health	Coastal Environmental Systems/Gaco Western Inc.	1/1/50	12/31/05
Jessica Eisner	ZymoGenetics Corporation	1/1/99	12/31/07
Ira Fielding	Retired	1/1/02	12/31/05
Grant Hendrickson	Retired	1/1/99	12/31/07
ChangMook Sohn, PhD	Washington Economic & Revenue Forecast Council	1/1/00	12/31/06
Pegge Till	Private Consulting Business	1/1/80	12/31/05

The Companies' management team is responsible for the day-to-day operations:

Name	Position
Scott Armstrong	President and Chief Executive Officer
Hugh Straley, MD	Medical Director
Jack Dutzar, MD	Executive Medical Director, Columbia Region
James Hereford	Executive Vice President
Janet Liang	Executive Vice President, Columbia Region

Name	Position
Pam MacEwan	Executive Vice President, Public Affairs and Governance
Maureen McLaughlin	Executive Vice President, Health Plan Sales and Marketing
Peter Morgan	Executive Vice President, Puget Sound Region
Michael Soman, MD	Executive Medical Director, Puget Sound Region
Jim Truess	Executive Vice President and Chief Financial Officer
Rick Woods	Executive Vice President and General Counsel

Territory of Operations

A Health care service contractor is required by RCW 48.44.040 to state its territory of operations at the time of registration with the OIC. Group Health Options, Inc. operates in the following counties in Washington State: Snohomish, King, Pierce, Thurston, Kitsap, Jefferson, San Juan, Whatcom, Skagit, Mason, Kittitas, Lewis, Yakima, Benton, Franklin, Walla Walla, Columbia, Whitman and Spokane. The Company also operates in parts of the following Washington counties: Grays Harbor, Pend Oreille, Stevens, Lincoln, and Adams.

Findings

The following Company Operations & Management Standards passed without comment:

	Company Operations & Management Standard	Reference
1	**The Company is required to be registered with the Office of Insurance Commissioner prior to acting as a health care service contractor or health maintenance organization in the State of Washington.**	**HCSC Reference**
		RCW 48.44.015(1)
		HMO Reference
		RCW 48.46.027(1)
2	**The Company is required to report to the OIC any changes to registration documents, including Articles of Incorporation, Bylaws, and Amendments at the same time as submitting such to the Secretary of State.**	**HCSC Reference**
		RCW 48.44.013
		HMO Reference
		RCW 48.46.012
3	**When the Company registers with the Office of Insurance Commissioner, it states its area of operations.**	**HCSC Reference**
		RCW 48.44.040
		HMO Reference
		None

	Company Operations & Management Standard	Reference
4	At least one-third of the HMO's board of directors is made up of consumers who are representative of the enrolled population.	HCSC Reference
		None
		HMO Reference
		RCW 48.46.070(1)

GENERAL EXAMINATION FINDINGS

The Companies' records and operations were reviewed to determine if the Companies do business in accordance with the requirements of this state.

The following General Examination Standards passed without comment:

#	General Examination Standards	Reference
1	The Company does business in good faith, and practices honesty and equity in all transactions.	HCSC/HMO Reference
		RCW 48.01.030
3	The Company may not discourage members from contacting the OIC and may not discriminate against those members that do contact the OIC.	HCSC/HMO Reference
		WAC 284-30-572(2)

The following General Examination Standard failed:

#	General Examination Standards	Reference
2	The Company facilitates the examination process by providing its accounts, records, documents and files to the examiners upon request.	HCSC Reference
		RCW 48.44.145(2)
		HMO Reference
		RCW 48.46.120(2)

General Examination Standard #2:

The progress of the examination was delayed due to the Companies' failure to provide records when requested. The examiners experienced difficulty in obtaining records for the following sections of the examination:

- Advertising – The Companies only provided broker, client, and member presentation materials in response to the initial data request. There were no pieces that fit the traditional definition of advertising such as direct mail, newspaper ads, magazine ads, radio spots, TV spots, or billboard copy. The initial submission of materials also did not include any circulars, leaflets, booklets, or illustrations. The examiners had to request, review and analyze an amended database, and select additional materials for review. The Companies failure to provide a complete listing of advertising materials placed a four-week delay on completion of this section of the examination.
- Rate and Form Filing/Underwriting – The examiners requested a sample of 200 files for review. The examiners were on site at the Companies' office from September 15,

2004 through September 20, 2004, reviewing files and gathering information necessary to test the examination standards for rate and form filing and underwriting. When the examiners returned to the OIC office on September 21, 2004, it was discovered that 62 files were not provided. A request for copies of these files was sent to the Companies via email on September 22, 2004. A due date of September 27, 2004 was defined. The majority of the files were provided on that date. However, delivery of all the files was not complete until October 1, 2004. As the examiners began reviewing the files, they noted that many of them were original files. The release of these original documents outside of GHC/GHO's possession demonstrates a lack of control over documentation and the potential for release of confidential information.

- Rate and Form Filing/Underwriting – The Companies were unable to provide three (3) GHO files that were requested for review.
- Underwriting – The examiners found that the information contained in the underwriting files provided was not consistent from file to file. Census information was missing from some of the files provided. Requests for additional information had to be made in order to test the standards.

When requested materials were not provided, the Companies indicated that the requests were misunderstood. Attempts to contact the examiners regarding any confusion were not initiated.

The examiners issued 50 requests for information to the Companies. Seven (7) of the replies to these requests were received after the established due dates.

ADVERTISING

Advertising Procedures

The Advertising & Marketing Communications Department is responsible for the preparation and maintenance of the advertising file for both GHC and GHO. Any published information is put through an approval review by marketing and communication staff, departmental directors, and the Companies' legal department.

Advertising Review

The Companies' advertising file consists of 448 items that were in use during the examination period. The examiners selected a random sample of 50 items to review and also reviewed the Companies' website.

Findings

The following Advertising Standards passed without comment:

#	Advertising Standard	Reference
1	The Company cannot advertise a plan to prevent illness or promote health unless a) the clinical preventive benefits are the same as the basic health plan; b) it monitors and reports annually to enrollees on standards of health care and satisfaction of enrollees; c) it makes available its plan to identify and manage the most prevalent diseases within its enrolled population on request.	HCSC/HMO Reference RCW 48.43.510(5), WAC 284-43-820(5)
2	No advertising may contain any false, deceptive or misleading information.	HCSC Reference RCW 48.44.110 HMO Reference RCW 48.46.400
3	The Company cannot make misleading comparisons with other companies to induce the consumer to change from another HCSC or HMO.	HCSC Reference RCW 48.44.140 HMO Reference RCW 48.46.410
6	The Company must comply with all health plan disclosures as required by regulation.	HCSC/HMO Reference WAC 284-43-820(1) through WAC 284-43-820(3)
7	The Company cannot misrepresent the terms, benefits, or advantages of the contract.	HCSC Reference RCW 48.44.120, WAC 284-50-050 HMO Reference RCW 48.46.060(2) and (3), WAC 284-50-050
8	A Health Care Service Contractor cannot guarantee future dividends or future refunds except in group contracts with an experience refund provision.	HCSC Reference RCW 48.44.130 HMO Reference None
9	No Health Maintenance Organization may use the words "insurance", "casualty", "surety", or "mutual" to describe itself in its advertising materials.	HCSC Reference None HMO Reference RCW 48.46.110(1)

The following Advertising Standards failed:

#	Advertising Standard	Reference
4	**The Company complies with the Washington Disability Insurance Advertising Regulations.**	**HCSC/HMO Reference**
		WAC 284-50-010 through WAC 284-50-230
5	**The Company maintains a complete advertising file.**	**HCSC/HMO Reference**
		WAC 284-50-200

Advertising Standard #4:

- **WAC 284-50-060(2):** Two (2) advertisements included the words "superior" and "ultimate" in a manner that exaggerates the benefits of the plans. See Appendix 1.
- **WAC 284-50-110(3):** The Companies cited statistical information without disclosure of the source of that information in five (5) PowerPoint presentations. See Appendix 1.

Subsequent Event: The Companies revised the advertising procedures effective June 7, 2005, instituting a production and review process to ensure compliance with the Washington Disability Insurance Advertising Regulations.

Advertising Standard #5:

The Companies provided only broker, client, and member presentation materials in response to the initial data request. There were no pieces that fit the traditional definition of advertising such as direct mail, newspaper ads, magazine ads, radio spots, TV spots, or billboard copy. The initial submission of materials also did not include any circulars, leaflets, booklets, or illustrations. The examiners had to request, review and analyze an amended database, and select additional materials for review. Company personnel stated that the failure to include these items was due to the fact that materials from another department were not included. The fact that the materials are located in separate areas indicates that there are no central controls in place to maintain a complete advertising file.

COMPLAINTS

Complaint Procedures

The Companies provided the examiners with the following documents for review:

- Provider Dispute Resolution Process for Interested Providers
- Provider Contract Dispute Resolution Process
- GHC Board Policies/Grievance Complaint Handling Desk Procedures
- Service Quality Department – Grievance Procedure for Quality of Care and Complicated Complaints
- Group Health Options, Inc. Medical Services Policy – Member Appeals First Level Appeals Policy

- Group Health Options Inc. Medical Services Policy – Expedited Appeal Policy
- D-01-001.2 First Level Appeal Procedure Revision (10/31/00)
- Expedited Non-Medicare Appeals Procedure (10/31/00)
- Group Health Cooperative Access Plan
- Group Health Options Access Plan

The examiners reviewed the materials and found them to be comprehensive. The procedures describe the Companies' processing of complaints, appeals and grievances.

Complaint Review

The following is a breakdown of the complaints received by the Companies from members, providers, and complaints routed to the Companies through the OIC, and the number of files randomly selected and reviewed:

Complaint Type	Total	Sample Size	Filed Reviewed
GHC Members	9,048	55	52
GHO Members	6,386	35	35
GHC Providers	172	6	6
GHO Providers	113	4	4
Company Complaints	**15,719**	**100**	**97***
OIC/GHC Complaints	54	32	40
OIC/GHO Complaints	31	18	9
OIC Complaints	**85**	**50**	**49****
TOTAL	**15,804**	**150**	**146**

*One (1) file was a duplicate of an OIC complaint file reviewed. Two (2) files involved a previous class-action settlement and were outside the scope of the examination period.
**One (1) file was removed from the sample. The Companies erroneously identified a file as an OIC complaint when it was not. It was not reviewed.

Findings

The following Complaints Standards passed without comment:

#	Complaints Standard	Reference
1	**The Company has filed a copy of its procedures for review and adjudication of complaints with the OIC.**	**HCSC/HMO Reference** **RCW 48.43.055**
3	**The Company provides enrollees access to independent review services to resolve disputes.**	**HCSC/HMO Reference** **RCW 48.43.535**
4	**Response to communications from the OIC must be within 15 business days of receipt of the correspondence. The response must contain the substantial information requested by the OIC.**	**HCSC/HMO Reference** **WAC 284-30-650, Technical Advisory T 98-4**

The following Complaints Standard passed with comment:

#	Complaints Standard	Reference
5	**The Company complies with procedures for health care service review decisions.**	**HCSC/HMO Reference** **WAC 284-43-620**

Complaints Standard #5:

One (1) complaint file did not comply with the procedures for health care service review decisions. WAC 284-43-620(1) requires that a carrier reconsider an adverse determination and notify a covered person of its decision within 14 days of receipt of an appeal unless the carrier notifies the covered person that an extension is necessary to complete review of the appeal.

- In one (1) case, a provider appealed the denial of a claim and was not provided acknowledgement of receipt of the appeal within 14 days. The Company stated that this complaint was a "provider reconsideration" rather than an appeal. However, documentation provided to the examiners clearly states "...provider appealing the denial of a claim..." (OIC #95, Case #3510550).

The following Complaints Standard failed:

#	Complaints Standard	Reference
2	**The Company maintains a fully operational, comprehensive grievance process.**	**RCW 48.43.530**

Complaints Standard #2:

The Companies do not provide amended explanations of benefits to its members if an original payment decision is modified. RCW 48.43.530(3) states that each carrier must provide written notice to an enrollee or the enrollee's designated representative, and the enrollee's provider, of its decision to modify payment.

CLAIMS

Claim Processing Manual

The Companies provided the Claims Administration Procedure Manual. The procedures are encompassing and detailed.

Claims Processing

The Companies processed claims on two separate systems during the examination period. Claims for Western Washington members were processed on the Premier system. Claims for members in Eastern Washington were processed on the HSII system. As of July 1, 2003, the Premier system became the intake point for all claims. Eastern Washington claims continued to

be priced in the HSII system and then transmitted back to the Premier system for payment. As of January 1, 2004, all claims were paid out of the Premier system.

During review of the claims, the examiners noted that new claims are opened in order to process adjustments to previous claims processing. One (1) claim (OIC #89) had three (3) related claim numbers that all represented the same instance of service. Claim #114268180 was the original claim, claim #114884528 was opened to void the original claim, and claim #114884531 was the replacement claim opened to issue corrected payment. This process leads to inflated claim numbers and distorts any tracking of clean and unclean claims.

Claims Review

The examiners randomly selected three (3) months during the examination period and asked the Companies to provide claims data for the months of September 2003, January 2004, and March 2004. The following is a breakdown of the claims population and random sample selected for review:

Company	# of Claims	Sample Selected	Claims Reviewed
GHC	487,803	100	100
GHO	268,574	100	100
TOTAL	**756,377**	**200**	**200**

The Companies provided the examiners with paper files, consisting of screen prints from its claims processing system. The claims were reviewed in the OIC's Seattle office.

Findings

The following Claims Standards passed without comment:

#	Claims Standard	Reference
1	**The Company shall provide no less than urgent and emergent care to a child who does not reside in the Company's service area.**	**HCSC/HMO Reference** **RCW 48.01.235(3)**
2	**The Company shall not retrospectively deny emergency or nonemergency care that had prior authorization.**	**HCSC/HMO Reference** **RCW 48.43.525(1)**
3	**The Company shall not deny an individual prescription drug claim that had prior authorization.**	**HCSC Reference** **RCW 48.44.465** **HMO Reference** **RCW 48.46.535**

#	Claims Standard	Reference
4	The Company shall not deny benefits for any service performed by a denturist if the service performed was within the lawful scope of such person's license, and the agreement would have provided benefits if services were performed by a dentist.	HCSC Reference
		RCW 48.43.180, RCW 48.44.500
		HMO Reference
		RCW 48.43.180, RCW 48.46.570
6	The denial of any claim must be communicated to the provider or facility with the specific reason the claim was denied.	HCSC/HMO Reference
		WAC 284-43-321(4)
8	The Company administers Coordination of Benefits provisions as required.	HCSC/HMO Reference
		Chapter 284-51 WAC
9	All plans must include every category of provider.	HCSC/HMO Reference
		RCW 48.43.045, WAC 284-43-205

The following Claims Standards failed:

#	Claims Standard	Reference
5	The Company pays or denies all claims according to the prescribed minimum standards.	HCSC/HMO Reference
		WAC 284-43-321(2)
7	The Company maintains a documented utilization review program with descriptions and conducts utilization review within the prescribed format defined.	HCSC/HMO Reference
		RCW 48.43.520, WAC 284-43-410

Claims Standard #5:

The Companies provided the examiners with copies of its clean claims reports for each month during the examination period. The examiners noted that the Companies did not meet the minimum 30-day standard of clean claim processing during four (4) months of the examination period. The following is a breakdown of those months that failed the standard:

Company	Month Reviewed	% of Clean Claims Processed
GHC	September 2003	93%
	January 2004	92%
	February 2004	93%
	March 2004	91%
GHO	September 2003	92%
	January 2004	90%
	February 2004	93%
	March 2004	91%

Subsequent Event: As of January 1, 2005, Eastern Washington claims will no longer be priced in the Company's HSII system. The Companies expect processing timeliness to improve upon the transition of all claims to the Premier system.

Claims Standard #7:

The examiners note that the Companies do not comply with WAC 284-43-410(5)(a) which states that review determinations must be made within two (2) business days of receipt of the necessary information on a proposed admission or service requiring a review determination. The Companies' procedure manual allows for 72 hours (3 days) from receipt of the request or as expeditiously as the patient's health requires for pre-service review.

Subsequent Event: The Companies provided a copy of its Utilization Management: Policies and Procedures that were revised August 5, 2005. The procedures correctly reflect the time requirements for review determinations.

AGENT ACTIVITY

The Companies provided the examiners with procedures for agent licensing and appointment. The procedures are detailed and accurately describe the processes involved in assuring that agents and brokers representing the Companies are licensed and appointed according to statute.

There were 940 active agents and brokers soliciting business on behalf of the Companies during the examination period. The examiners reviewed the licensing data for the agents and brokers associated with the group files selected for review in the Underwriting and Rates and Forms sections of this exam. The records for 108 agents and brokers were reviewed along with the records of 56 persons employed in a marketing capacity by the Companies. Of the 56 marketing personnel, the examiners reviewed the revocations of appointments for five (5) agents. The appointments were revoked because these employees left the Companies of their own accord.

Findings

The following Agent Activity Standard passed without comment:

#	Agent Activity Standard	Reference
3	**The Company must provide the agent with written notice of revocation of appointment and send a copy to the OIC.**	**HCSC/HMO Reference** **RCW 48.17.160(3)**

The following Agent Activity Standards failed:

#	Agent Activity Standard	Reference
1	**The Company requires that agents and brokers are licensed for the appropriate line of business with the State of Washington prior to allowing them to solicit business or represent the Company in any way.**	**HCSC Reference**
		RCW 48.17.060(1), RCW 48.17.060(2), RCW 48.44.011(2)
		HMO Reference
		RCW 48.17.060(1), RCW 48.17.060(2), RCW 48.46.023(2)
2	**The Company ensures that agents are appointed to represent the Company prior to allowing them to solicit business on behalf of the Company.**	**HCSC Reference**
		RCW 48.17.160(1), RCW 48.44.011(2)
		HMO Reference
		RCW 48.17.160(1), RCW 48.46.023(2)

Agent Activity Standard #1:
Six (6) agents and brokers were not licensed at the time that business was solicited on behalf of the Companies. See Appendix 2.

Subsequent Event: In April 2005, the Companies implemented procedures to confirm agent and broker licensing status on the OIC website.

Agent Activity Standard #2:
Four (4) agents were not appointed directly with the Companies or affiliated with a broker or agency prior to solicitation of business on the Companies' behalf. See Appendix 2.

Subsequent Event: In March 2005, the Companies instituted system changes that designate an agent's licensing status with the Companies. Marketing personnel are now unable to release information to an agent unless that agent's status is flagged as "active" within the system.

RATE AND FORM FILING

The Companies provided a listing of rate and form filings during the examination period along with copies of the transmittal sheets accompanying the filings. Only the rate filings submitted by the Companies were reviewed as a part of this examination.

Rate Filing Review

The examiners requested a database of the Companies' new groups, inforce groups, and quotes for the examination period. The following is a breakdown of the population and sample sizes selected for review:

Type	Company	Total Population	Sample Size Selected
New Groups	GHC	211	16
	GHO	445	34
Inforce Groups	GHC	2,347	23
	GHO	2,646	27
Quotes	GHC/GHO	7,343	50
TOTAL		**12,992**	**150***

*The Companies were unable to provide three (3) of the files selected, reducing the number of files reviewed to 147. Failure to produce these files is addressed under General Examination Findings.

Findings

Standard #1 was not tested as the Companies' filings for contract forms were not reviewed.

The following Rate and Form Filing Standard passed without comment:

#	Rate and Form Filing Standard	Reference
3	**All contract forms and rates have been filed with the OIC on transmittal forms prescribed by and available from the Commissioner.**	**HCSC/HMO Reference** **WAC 284-43-925**

The following Rate and Form Filing Standard failed:

#	Rate and Form Filing Standard	Reference
2	**All rates have been filed with the OIC prior to use.**	**HCSC Reference** **RCW 48.44.040, WAC 284-43-920** **HMO Reference** **RCW 48.46.062(3), WAC 284-43-920**

Rate and Form Filing Standard #2:

The examiners were unable to confirm the 2003 rates for the large groups within the sample files reviewed. The Companies informed the examiners that stop loss charges were omitted from the rate filing for its Options Classic and Alliant Plus plans in error. The Companies included the unfiled stop loss charge in its billed rates. There were 228 groups that were impacted by this omission in the filing.

The Companies also informed the examiners that the rates for its $15/$25 pharmacy benefit were incorrectly filed. The filed rates reflected a 15 percent trend. The actual rates that the Companies used in its rating model reflected a trend of 12 percent.

UNDERWRITING

Underwriting Manuals

The Companies provided the Underwriting Manual in effect for each company during the examination period. The examiners found the procedures to be detailed and comprehensive. All of the enrollment procedures were found to be correct with the exception of its policy regarding the enrollment of dependent children. The procedures state that only "the legally responsible parent may enroll" a dependent child. This statement is not in compliance with RCW 48.01.235. While reviewing the underwriting file sample, the examiners did not note any application of this procedure, and the Companies informed the examiners that the language in the manual was "outdated."

Subsequent Event: On August 17, 2004, the Companies revised the language in its underwriting procedures manual to state that dependent children will be enrolled when there is a court order to do so, through the other parent, Department of Social and Health Services, or child support enforcement.

Underwriting File Review

The examiners requested a database of the Companies' new groups and inforce groups for the examination period. The following is a breakdown of the population and sample sizes selected for review:

Type	Company	Total Population	Sample Size Selected
New Groups	GHC	211	16
	GHO	445	34
Inforce Groups	GHC	2,347	23
	GHO	2,646	27
TOTAL		**5,649**	**100***

*The Companies were unable to provide three (3) of the files selected for review, reducing the number of files reviewed to 97. Failure to produce these files is addressed under General Examination Findings.

The examiners also noted that the documentation contained in the files provided was inconsistent from file to file. Requests for additional information needed to test the standards had to be made in order to complete this section of the examination.

Findings

The following Underwriting Standards passed without comment:

#	Underwriting Standard	Reference
1	The Company complies with the prescribed requirements for enrollment and coverage of a child under the health plan of the child's parent.	HCSC Reference
		RCW 48.01.235, RCW 48.44.212
		HMO Reference
		RCW 48.01.235, RCW 48.46.250
2	The Company appropriately reduces preexisting condition exclusions, limitations, or waiting periods in its large group, small group and individual plans by applying time covered by the preceding health plan coverage.	HCSC/HMO Reference
		RCW 48.43.015, WAC 284-43-710
3	The Company may not reject an individual for health plan coverage in a large or small group based upon preexisting conditions of the individual. The Company may not deny, exclude, or limit coverage for an individual's preexisting health conditions. The Company shall accept any state resident within the group and within the Company's service area.	HCSC/HMO Reference
		RCW 48.43.025, RCW 48.43.035(1), WAC 284-43-720
4	Eligibility to purchase a health benefit plan must be extended to all small employers and small groups as defined in RCW 48.43.005(24).	HCSC/HMO Reference
		RCW 48.43.028
5	Dependent children cannot be terminated from an individual or group plan because of developmental disability or physical handicap.	HCSC Reference
		RCW 48.44.200, RCW 48.44.210
		HMO Reference
		RCW 48.46.320
6	All plans shall cover newborn infants and congenital anomalies from the moment of birth. The notification period and payment of required premium to the Company shall be no less than 60 days from the date of birth.	HCSC Reference
		RCW 48.44.212(1)
		HMO Reference
		RCW 48.46.250(1)
7	No plan may deny coverage solely on account of race, religion, national origin, or the presence of any sensory, mental, or physical handicap.	HCSC Reference
		RCW 48.44.220
		HMO Reference
		RCW 48.46.060(5), RCW 48.46.370

#	Underwriting Standard	Reference
8	**The Company may not refuse, cancel, or decline coverage solely because of a mastectomy or lumpectomy more than five (5) years prior.**	**HCSC Reference**
		RCW 48.44.335
		HMO Reference
		RCW 48.46.285
9	**Adoptive children shall be covered on the same basis as other dependents. The notification period and payment of required premium to the Company shall be no less than 60 days from the date of birth.**	**HCSC Reference**
		RCW 48.44.420
		HMO Reference
		RCW 48.46.490

PROVIDER ACTIVITY

Provider Contracting Process

The Group Health Provider Relations Department is responsible for negotiating and managing provider contracts. Every practitioner planning to enter into a contractual agreement with the Companies must complete a credentialing process and be approved by the Credentialing Committee prior to contracting with the Companies or treating any members. When the credentialing process is complete and the practitioner has been approved, he/she is notified in writing. Once the contract with GHC/GHO is finalized, the practitioner may begin to provide services to members.

Provider Manual

The Companies provided the examiners with the following:

- Provider Relations Contracting Unit – Standard Operating Procedures
- Contracted Provider Manual

The standard operating procedures were found to be comprehensive and no violations were noted. There was one document in the provider manual that states: "If the mediation process does not result in agreement and dispute resolution, completion of Group Health's dispute resolution process ends with completion of the mediation process." This violates WAC 284-43-322(4).

Provider Directories

The Companies provided the examiners with 14 provider directories that were in use during the examination period. The examiners selected the Companies' January 2004 Group Health, GH Options, and Options Select Provider Directory for review as it was the most recent directory that included providers for the plans in the scope of the examination. The directory indicates

that the Companies operate within the stated territory of operations. No problems or violations were noted.

Provider Contract Review

A random sample of 50 providers, 5 hospitals and 5 pharmacies was selected from the Group Health, GH Options and Options Select Provider Directory (1GG 01-04). There were 22 different provider contract forms among the 60 providers that were reviewed.

Findings

The following Provider Activity Standards passed without comment:

#	Provider Activity Standard	Reference
1	All plans allow enrollees to select a primary care provider who is accepting new patients from a list of participating providers.	HCSC/HMO Reference RCW 48.43.515, WAC 284-43-251
3	The Company standards for selection of participating providers do not result in risk avoidance or discrimination by excluding providers or facilities specializing in specific treatments or located in high risk geographic areas.	HCSC/HMO Reference WAC 284-43-310(1)(a), WAC 284-43-310(1)(b)
4	The Company establishes a mechanism by which its participating providers can obtain eligibility and benefits information.	HCSC/HMO Reference WAC 284-43-320(1)
5	The Company notifies all providers of their responsibilities regarding the Company's administrative policies and programs.	HCSC/HMO Reference WAC 284-43-320(4)
6	The Company does not preclude the provider from informing the patient of care required and whether such care is consistent with medical necessity, medical appropriateness, or covered by the plan.	HCSC/HMO Reference WAC 284-43-320(5)(a)
7	The Company does not preclude or discourage providers from discussing the merits of other carriers even if critical of a carrier.	HCSC/HMO Reference WAC 284-43-320(5)(b)
8	The Company and the provider will provide at least 60 days written notice to each other before terminating the contract without cause.	HCSC/HMO Reference WAC 284-43-320(7)

The following Provider Activity Standard failed:

#	Provider Activity Standard	Reference
2	**All provider contract forms must be filed with and approved by the OIC prior to use.**	**HCSC Reference**
		RCW 48.44.070, WAC 284-43-330
		HMO Reference
		RCW 48.46.243(3), WAC 284-43-330

Provider Activity Standard #2:

There were four (4) provider contract forms that reflected form numbers that did not match the filed form numbers. The Companies stated that these forms were filed but identified by different form numbers in the filing. The examiners confirmed that the contract language in these forms did match the actual filed forms. However, confirmation of filing and identification of these forms was made difficult due to the Companies changing the form numbers.

There were three (3) provider contract forms that were used prior to being filed with or approved by the OIC. The Companies informed the examiners that procedures were implemented in May 2004 establishing an auditing process to assure that only filed and approved forms are used in the contracting of providers.

See Appendix 3.

INSTRUCTIONS

	INSTRUCTIONS	PAGE #
1	The Companies are instructed to provide their accounts, records, documents, and files to the examiners upon request in order to facilitate the examination process. Reference: RCW 48.44.145(2), RCW 48.46.120(2). (General Examination Standard #2.)	10
2	The Companies are instructed to cease using words in their advertisements that exaggerate the benefits of their plans. Reference: WAC 284-50-060(2). (Advertising Standard #4.)	13
3	The Companies are instructed to cite the source of statistical information used in their advertisements. Reference: WAC 284-50-110(3). (Advertising Standard #4.)	13
4	The Companies are instructed to maintain a complete advertising file and to demonstrate that they have control of the file in one location. Reference: WAC 284-50-200. (Advertising Standard #5.)	13
5	The Companies are instructed to provide amended explanations of benefits to their members if original payment is modified in any way. Reference: RCW 48.43.530(3). (Complaints Standard #2.)	15
6	The Companies are instructed to pay or deny all claims according to prescribed minimum standards. Reference: WAC 284-43-321(2). (Claims Standard #5.)	17
7	The Companies are instructed to conduct review determinations within two (2) business days of receipt of necessary information on proposed admissions or services requiring review determinations. Reference: WAC 284-43-410(5)(a). (Claims Standard #7.)	17
8	The Companies are instructed to assure that agents and brokers hold an appropriate license prior to soliciting business or representing the Companies. Reference: RCW 48.17.060(1), RCW 48.17.060(2), RCW 48.44.011(2), RCW 48.46.023(2). (Agent Activity Standard #1.)	19
9	The Companies are instructed to appoint agents to represent the Companies prior to allowing agents to solicit business. Reference: RCW 48.17.160(1), RCW 48.44.011(2), RCW 48.46.023(2). (Agent Activity Standard #2.)	19
10	The Companies are instructed to file their rates prior to use. Reference: RCW 48.44.040, RCW 48.46.062(3), WAC 284-43-920. (Rate and Form Filing Standard #2.)	20
11	The Companies are instructed to audit their 2003 groups that were sold the Options Classic and/or Alliant Plus plans. Refunds of overcharges resulting from the unfiled stop loss fees must be issued within 90 days from the adoption of the report. The Companies will notify the OIC of the results of the audit and the amounts of the refunds to each group. RCW 48.44.040, RCW 48.46.062(3), WAC 284-43-920. (Rate and Form Filing Standard #2.)	20

	INSTRUCTIONS	PAGE #
12	The Companies are instructed to file their provider contract forms with the OIC and to obtain approval from the OIC prior to use. Reference: RCW 48.44.070, RCW 48.46.243(3), WAC 284-43-330. (Provider Activity Standard #2.)	25

RECOMMENDATIONS

	RECOMMENDATIONS	PAGE #
1	It is recommended that the Companies treat appeals of claim denials from providers the same as any other adverse determinations and notify appropriate parties of their decisions within 14 days of receipt of any appeal. Reference: WAC 284-43-620. (Complaints Standard #5.)	15

SUMMARY OF STANDARDS

Company Operations and Management:

#	STANDARD	PAGE	PASS	FAIL
1	The Company is required to be registered with the Office of Insurance Commissioner prior to acting as a health care service contractor or health maintenance organization in the State of Washington. Reference: RCW 48.44.015(1), RCW 48.46.027(1).	9	X	
2	The Company is required to report to the OIC any changes to the registration documents, including Articles of Incorporation, Bylaws, and Amendments at the same time as submitting such documents to the Secretary of State. Reference: RCW 48.44.013, RCW 48.46.012.	9	X	
3	When the Company registers with the Office of Insurance Commissioner, it states its area of operations. Reference: RCW 48.44.040.	9	X	
4	At least one-third of the HMO's board of directors is made up of consumers who are representative of the enrolled population. Reference: RCW 48.46.070(1).	10	X	

General Examination Findings:

#	STANDARD	PAGE	PASS	FAIL
1	The Company does business in good faith, and practices honesty and equity in all transactions. Reference: RCW 48.01.030.	10	X	
2	The Company facilitates the examination process by providing its accounts, records, documents and files to the examiners upon request. Reference: RCW 48.44.145(2), RCW 48.46.120(2).	10		X
3	The Company may not discourage members from contacting the OIC and may not discriminate against those members that do contact the OIC. Reference: WAC 284-30-572(2).	10	X	

Advertising:

#	STANDARD	PAGE	PASS	FAIL
1	The Company cannot advertise a plan to prevent illness or promote health unless a) the clinical preventive benefits are the same as the basic health plan; b) it monitors and reports annually to enrollees on standards of health care and satisfaction of enrollees; c) it makes available its plan to identify and manage the most prevalent diseases within its enrolled population on request. Reference: RCW 48.43.510(5), WAC 284-43-820(5).	12	X	
2	No advertising may contain any false, deceptive or misleading information. Reference: RCW 48.44.110, RCW 48.46.400.	12	X	
3	The Company cannot make misleading comparisons with other companies to induce the consumer to change from another HCSC or HMO. Reference: RCW 48.44.140, RCW 48.46.410.	12	X	
4	The Company complies with the Washington Disability Insurance Advertising Regulations. Reference: WAC 284-50-010 through WAC 284-50-230.	13		X
5	The Company maintains a complete advertising file. Reference: WAC 284-50-200.	13		X
6	The Company must comply with all health plan disclosures as required by regulation. Reference: WAC 284-43-820(1) through WAC 284-43-820(3).	12	X	
7	The Company cannot misrepresent the terms, benefits, or advantages of the contract. Reference: RCW 48.44.120, RCW 48.46.060(2) and (3), WAC 284-50-050.	12	X	
8	A Health Care Service Contractor cannot guarantee future dividends or future refunds except in group contracts with an experience refund provision. Reference: RCW 48.44.130.	12	X	
9	No Health Maintenance Organization may use the words "insurance", "casualty", "surety" or "mutual" to describe itself in its advertising materials. Reference: RCW 48.46.110(1).	12	X	

Complaints:

#	STANDARD	PAGE	PASS	FAIL
1	The Company has filed a copy of its procedures for review and adjudication of complaints with the OIC. Reference: RCW 48.43.055.	14	X	
2	The Company maintains a fully operational, comprehensive grievance process. Reference: RCW 48.43.530.	15		X
3	The Company provides enrollees access to independent review services to resolve disputes. Reference: RCW 48.43.535.	14	X	

#	STANDARD	PAGE	PASS	FAIL
4	Response to communications from the OIC must be within 15 business days of receipt of the correspondence. The response must contain the substantial information requested by the OIC. Reference: WAC 284-30-650, Technical Advisory T 98-4.	14	X	
5	The Company complies with procedures for health care service review decisions. Reference: WAC 284-43-620.	15	X	

Claims:

#	STANDARD	PAGE	PASS	FAIL
1	The Company shall provide no less than urgent and emergent care to a child who does not reside in the Company's service area. Reference: RCW 48.01.235(3).	16	X	
2	The Company shall not retrospectively deny emergency or non-emergency care that had prior authorization. Reference: RCW 48.43.525(1).	16	X	
3	The Company shall not deny an individual prescription drug claim that had prior authorization. Reference: RCW 48.44.465, RCW 48.46.535.	16	X	
4	The Company shall not deny benefits for any service performed by a denturist if the service performed was within the lawful scope of such person's license, and the agreement would have provided benefits if services were performed by a dentist. Reference: RCW 48.43.180, RCW 48.44.500, RCW 48.46.570.	17	X	
5	The Company pays or denies all claims according to the prescribed minimum standards. Reference: WAC 284-43-321(2).	17		X
6	The denial of any claim must be communicated to the provider or facility with the specific reason the claim was denied. Reference: WAC 284-43-321(4).	17	X	
7	The Company maintains a documented utilization review program with descriptions and conducts utilization review within the prescribed format defined. Reference: RCW 48.43.520, WAC 284-43-410.	17		X
8	The Company administers Coordination of Benefits provisions as required. Reference: Chapter 284-51 WAC.	17	X	
9	All plans must include every category of provider. Reference: RCW 48.43.045, WAC 284-43-205.	17	X	

Agent Activity:

#	STANDARD	PAGE	PASS	FAIL
1	The Company requires that agents and brokers are licensed for the appropriate line of business with the State of Washington prior to allowing them to solicit business or represent the Company in any way. Reference: RCW 48.17.060(1), RCW 48.17.060(2), RCW 48.44.011(2), RCW 48.46.023(2).	19		X
2	The Company ensures that agents are appointed to represent the Company prior to allowing them to solicit business on behalf of the Company. Reference: RCW 48.17.160(1), RCW 48.44.011(2), RCW 48.46.023(2).	19		X
3	The Company must provide the agent with written notice of revocation of appointment and send a copy to the OIC. Reference: RCW 48.17.160(3).	18	X	

Rate and Form Filing:

#	STANDARD	PAGE	PASS	FAIL
1	All contract forms have been filed with and approved by the OIC prior to use. Reference: RCW 48.44.040, RCW 48.46.030(7)(g), RCW 48.46.030(7)(h), AC 284-43-920.	20	N/A	N/A
2	All rates have been filed with the OIC prior to use. Reference: RCW 48.44.040, RCW 48.46.062(3), WAC 284-43-920.	20		X
3	All contract forms and rates have been filed with the OIC on transmittal forms prescribed by and available from the Commissioner. Reference: WAC 284-43-925.	20	X	

Underwriting:

#	STANDARD	PAGE	PASS	FAIL
1	The Company complies with the prescribed requirements for enrollment and coverage of a child under the health plan of the child's parent. Reference: RCW 48.01.235, RCW 48.44.212, RCW 48.46.250.	22	X	
2	The Company appropriately reduces preexisting condition exclusions, limitations, or waiting periods in its large group, small group and individual plans by applying time covered by the preceding health plan coverage. Reference: RCW 48.43.015, WAC 284-43-710.	22	X	

#	STANDARD	PAGE	PASS	FAIL
3	The Company may not reject an individual for health plan coverage in a large or small group based upon preexisting conditions of the individual. The Company may not deny, exclude, or limit coverage for an individual's preexisting health conditions. The Company shall accept any state resident within the group and within the Company's service area. Reference: RCW 48.43.025, RCW 48.43.035(1), WAC 284-43-720.	22	X	
4	Eligibility to purchase a health benefit plan must be extended to all small employers and small groups as defined in RCW 48.43.005(24). Reference: RCW 48.43.028.	22	X	
5	Dependent children cannot be terminated from an individual or group plan because of developmental disability or physical handicap. Reference: RCW 48.44.200, RCW 48.44.210, RCW 48.46.320.	22	X	
6	All plans shall cover newborn infants and congenital anomalies from the moment of birth. The notification period and payment of required premium to the Company shall be no less than 60 days from the date of birth. Reference: RCW 48.44.212(1), RCW 48.46.250(1).	22	X	
7	No plan may deny coverage solely on account of race, religion, national origin, or the presence of any sensory, mental, or physical handicap. Reference: RCW 48.44.220. RCW 48.46.060(5), RCW 48.46.370.	22	X	
8	The Company may not refuse, cancel, or decline coverage solely because of a mastectomy or lumpectomy more than five (5) years prior. Reference: RCW 48.44.335, RCW 48.46.285.	23	X	
9	Adoptive children shall be covered on the same basis as other dependents. The notification period and payment of required premium to the Company shall be no less than 60 days from the date of birth. Reference: RCW 48.44.420, RCW 48.46.490.	23	X	

Provider Activity:

#	STANDARD	PAGE	PASS	FAIL
1	All plans allow enrollees to select a primary care provider who is accepting new patients from a list of participating providers. Reference: RCW 48.43.515, WAC 284-43-251.	24	X	
2	All provider contract forms must be filed with and approved by the OIC prior to use. Reference: RCW 48.44.070, RCW 48.46.243(3), WAC 284-43-330.	25		X

#	STANDARD	PAGE	PASS	FAIL
3	The Company standards for selection of participating providers do not result in risk avoidance or discrimination by excluding providers or facilities specializing in specific treatments or located in high risk geographic areas. Reference: WAC 284-43-310(1)(a), WAC 284-43-310(1)(b).	24	X	
4	The Company establishes a mechanism by which its participating providers can obtain eligibility and benefits information. Reference: WAC 284-43-320(1).	24	X	
5	The Company notifies all providers of their responsibilities regarding the Company's administrative policies and programs. Reference: WAC 284-43-320(4).	24	X	
6	The Company does not preclude the provider from informing the patient of care required and whether such care is consistent with medical necessity, medical appropriateness, or covered by the plan. Reference: WAC 284-43-320(5)(a).	24	X	
7	The Company does not preclude or discourage providers from discussing the merits of other carriers even if critical of a carrier. Reference: WAC 284-43-320(5)(b).	24	X	
8	The Company and the provider will provide at least 60 days written notice to each other before terminating the contract without cause. Reference: WAC 284-43-320(7).	24	X	

Advertising Standard #4: The Company complies with the Washington Disability Insurance Advertising Regulations. Reference: WAC 284-50-010 through WAC 284-50-230.

WAC 284-50-060(2): No advertisement shall contain or used words or phrases in a manner which exaggerates any benefits beyond the terms of the policy.

OIC #	Company #	Description	Comments
19	1928	PowerPoint Presentation	Ad states "Group Health is producing superior value through…"
45	2229	PowerPoint Presentation	a)Ad states "It's the ultimate in health care convenience." b)Ad states "We are producing superior value through…"

WAC 284-50-110(3): The source of any statistics used in an advertisement shall be identified in such advertisement.

OIC #	Company #	Description
9	1094	PowerPoint Presentation
19	1928	PowerPoint Presentation
23	1984	PowerPoint Presentation
33	2056	PowerPoint Presentation
45	2229	PowerPoint Presentation

APPENDIX 2

Agent Activity Standard #1: The Company requires that agents and brokers are licensed for the appropriate line of business with the State of Washington prior to allowing them to solicit business or represent the Company in any way. Reference: RCW 48.17.060(1), RCW 48.17.060(2), RCW 48.44.011(2), RCW 48.46.023(2).

Agent Activity Standard #2: The Company ensures that agents are appointed to represent the Company prior to allowing them to solicit business on behalf of the Company. Reference: RCW 48.17.160(1), RCW 48.44.011(2), RCW 48.46.023(2).

OIC ID #	Company Agent #	Std #1	Std #2	Comments
5	H1347	X		Agent representing agency is not licensed in the State of Washington
34	H0859	X		Agent representing broker is not licensed in the State of Washington
35	H0859	X		Agent representing broker is not licensed in the State of Washington
36	BH124	X		Agent representing agency is not licensed in the State of Washington
37	H1554	X		Agent representing agency is not licensed in the State of Washington
57	BH628		X	3/12/98 agency appointment expired 10/23/03. Reappointed with GHO on 7/12/04. Plan was effective 1/1/04.
80	H1531		X	Quote issued 11/4/03. GHO appointment was valid 3/27/03 to 10/23/03. Reappointed on 1/7/04.
82	H1570		X	Quotes issued 11/13/03. GHC appointment was effective 11/20/03. GHO appointment was effective 11/24/03.
84	H1428		X	Quotes issued 11/25/03. GHC appointment was effective 12/12/03.
99	BH699	X		Quotes were effective 4/1/03. Agent representing the broker was not licensed or appointed until 5/17/03.

APPENDIX 3

Provider Activity Standard #2: All provider contract forms must be filed with and approved by the OIC prior to use. Reference: RCW 48.44.070, RCW 48.46.243(3), WAC 284-43-330

Contract Form #	Comments
BHA01-01 Revised 12 April 2001	Filed as MS 01-01 on 5/21/01; approved 5/23/01; effective 5/18/01.
BH03-02 Revised March 2002	Filed as MS 03-02 on 5/12/03; approved 5/19/03; effective 6/1/03.
HB04-01 Revised March 2004	Filed as MS 04-01 on 12/5/03; approved 12/15/03; effective 1/1/04.
MLA/dr/A-ms Revised November 1998	Companies referred examiners to MS-OIC-98. Form was filed as GCONBPBPMSOIC98 on 5/1/98; approved 5/27/98; effective 5/15/98.
PCP-SPEC01-01 Revised April 2001	Used 2/1/02; filed 1/21/03; approved 1/24/03
MS02-01 Revised March 2002	Used 1/1/02; filed 8/15/02; approved 8/22/02
Med Impact GHC.doc Revised 11-26-99	Used 12/2/99; filed 12/6/99; approved 1/2/00

Group Health Cooperative

521 Wall St
Seattle, WA 98121-1536

October 6, 2005

DELIVERY VIA DHL EXPRESS
James T. Odiorne, CPA, JD
Deputy Insurance Commissioner
Company Supervision Division
Office of the Insurance Commissioner
P.O. Box 40255
Olympia, WA 98504-0255

RE: Market Conduct Examination of Group Health Cooperative and Group Health Options, Inc.

Dear Deputy Commissioner Odiorne,

Thank you for the opportunity to respond to the draft market conduct examination report that your office prepared for Group Health Cooperative and Group Health Options, Inc. (referred to collectively as "Group Health") and for the opportunity to meet with your staff. By agreement, Group Health's response to the draft examination report will be in two parts. This first part will contain Group Health's comments to all sections of the draft examination report except the General Examination Findings. Group Health will respond to the General Examination Findings once your office presents us with the updated version of that section.

We offer the following comments regarding the Instructions, beginning with Instruction number 2.

2. The Companies are instructed to cease using words in their advertisements that exaggerate the benefits of their plans. Reference: WAC 284-50-060(2).

While we agree with the standard pertaining to this instruction, we do not agree with the referenced Exam finding that material in the two cited Group Health power point presentations exaggerated the benefits of Group Health plans. Group Health has processes in place to review advertising for misleading text and remains committed to avoid using text that misrepresents plan benefits.

3. The Companies are instructed to cite the source of statistical information used in their advertisements. Reference: WAC 284-50-110(3).

Group Health agrees with this standard and the instruction. As noted in the draft report, prior to the issuance of that report Group Health had already instituted an enhanced advertising review procedure to ensure compliance with this and other advertising standards.

4. The Companies are instructed to maintain a complete advertising file and to demonstrate that they have control of the file in one location. Reference: WAC 284-50-200.

Consistent with the requirements of WAC 284-50-200, Group Health has continuously maintained at its home office the advertising materials produced by several Group Health departments, who produce and catalogue these materials. Group Health has been further consolidating its production and maintenance of advertising materials to allow for more timely provision of our advertising material at the request of the Commissioner's office.

5. The Companies are instructed to provide amended explanations of benefits to their members if original payment is modified in any way. Reference: RCW 48.43.530(3).

Group Health will revise its policies and procedures to provide members with an amended Explanation of Benefits when a decision is made which impacts payment, coverage, authorization or the provision of health care services or benefits.

6. The Companies are instructed to pay or deny all claims according to prescribed minimum standards. Reference: WAC 284-43-321(2).

The examination report noted that Group Health claims originating in Eastern Washington were transitioned to the Premier system. This system change, with other changes that were implemented in March, 2005, are designed to improve claims processing. As a result, we have noted improvement in claims processing timelines and believe this issue has been resolved. The data for the most recent month for which information is available indicates that 97.5% of all claims received (including both Medicare and commercial claims) were paid within 30 days of receipt.

7. The Companies are instructed to conduct review determinations within two (2) business days of receipt of necessary information on proposed admissions or services requiring review determinations. Reference: WAC 284-43-410(5)(a).

Group Health conducts review determinations within two business days of receipt of necessary information, consistent with the terms of WAC 284-43-410(5)(a). Group Health also conducts its review more expeditiously for urgent/emergent requests; in those cases, the review is conducted within 72 hours of receipt of a request or as expeditiously as the member's condition requires. In these situations, Group Health applies the most stringent

standard required under federal law, NCQA accreditation standards, and state statute and regulation.

These standards (including the two-business day requirement) are reflected in the current Group Health Clinical and Utilization Review policy, attached. However, the two-business day requirement is not reflected in the Referral policy that was reviewed by the examiners. Group Health will revise its Referral policies and the Clinical and Utilization Review procedures to better clarify that in the event both the two-business day and the 72-hour standards apply, the more expeditious of the two standards will be followed. In no event will the maximum timeframe standard in WAC 284-43-410(5)(a) be exceeded. This has been Group Health's practice since before the examination began, and we will clarify that practice in our documentation.

8. The Companies are instructed to assure that agents and brokers hold an appropriate license prior to soliciting business or representing the Companies. Reference: RCW 48.17.060(1), RCW 48.17.060(2), RCW 48.44.011(2), RCW 48.46.023(2).

Group Health complies with this standard. In late 2003, Group Health began a staff education effort focused on the issue of licensing of agents, followed by system changes in early 2004 to improve Group Health's compliance in this area. Group Health also reviews the OIC's website to confirm that agents and brokers are licensed with the state and has done so since the OIC started providing this online service last April.

9. The Companies are instructed to appoint agents to represent the Companies prior to allowing agents to solicit business. Reference: RCW 48.17.160(1), RCW 48.44.011(2), RCW 48.46.023(2).

Group Health complies with this standard. In late 2003, Group Health began a staff education effort focused on the issue of appointment of agents, followed by system changes in early 2004 to improve Group Health's compliance in this area. As noted in the draft report, Group Health also instituted a system change in March 2005, which prevents an agent from being identified as "active" until completion of the appointment process.

10. The Companies are instructed to file their rates prior to use. Reference: RCW 48.44.040, RCW 48.46.062(3), WAC 284-43-920.

Group Health is in compliance with this standard. In the two matters identified in the examination report, Group Health filed the rates, but made an error in either the content of the filing or in the implementation model. In the second case, involving the Options out-of-network pharmacy benefit, Group Health's error resulted in an undercharging of the involved groups.

Since mid-2004, Group Health has instituted process improvements to allow a more proactive identification and correction of the errors that occurred in these two instances.

11. **The Companies are instructed to audit their 2003 groups that were sold the Options Classic and/or Alliant Plus plans. Refunds of overcharges resulting from the unfiled stop loss fees must be issued within 90 days from the adoption of the report. The Companies will notify the OIC of the results of the audit and the amounts of the refunds to each group. RCW 48.44.040, RCW 48.46.062(3), WAC 284-43-920.**

Group Health will comply with this instruction with respect to the Washington large groups impacted by this error.

12. **The Companies are instructed to file their provider contract forms with the OIC and to obtain approval from OIC prior to use. Reference: RCW 48.44.070, RCW 48.46.243(3), WAC 284-43-330.**

Group Health is in compliance with this standard. Of the 60 provider contracts reviewed, the examiners found three contracts that had been used prior to approval; of those three, all of them had been filed with and approved by the Office of the Insurance Commissioner well before the examination began (one of them had been approved for use in January 2000, one was approved in August 2002, and the third was approved in January 2003). Moreover, Group Health instituted internal audit, review and approval processes in 2003 and a change in procedures in 2004 to assure that only filed and approved forms are used in contracting of providers.

We offer the following comments regarding the Recommendations:

1. **It is recommended that the Companies treat appeals of claim denials from providers the same as any other adverse determinations and notify appropriate parties of their decisions within 14 days of receipt of any appeal. Reference: WAC 284-43-620.**

Group Health acknowledges that the provider case file that led to this recommendation contained an error in terminology by Group Health staff. This led examiners to conclude that this case involved an appeal of an adverse determination. In reality, the case was not an appeal of an adverse determination but rather a request from a provider to review a claim with regard to appropriate payment in accordance with the provider's contract with Group Health. We believe that Group Health responded to the request in an appropriate manner and consistent with state requirements. To avoid this occurring in the future, GHC has educated its employees on correct terminology to use when classifying and resolving provider disputes.

Thank you for the opportunity to review and respond to your findings. We await the opportunity to comment on the General Examination Findings when provided to Group Health. Please feel free to contact me if you have questions.

Sincerely,

Maureen McLaughlin

Maureen McLaughlin
Executive Vice President, Health Plan Division, Group Health Cooperative
President and CEO, Group Health Options, Inc.

Enclosure

CC: Scott Plack, Director of Regulatory Affairs, Group Health Cooperative

Utilization Management: Policies & Procedures

Policies Index

Clinical and Utilization Review	Policy Number: UM102
	Adopted: 1995
	Review Dates: 7/1998, 10/1998, 11/1999, 6/30/2000, 9/6/2001, 9/26/2002, 9/25/2003, 9/28/2004
	Revised Dates: 7/1998, 10/1998, 11/1999, 6/30/2000, 9/6/2001, 9/26/2002, 9/25/2003, 9/28/2004

POLICY

Clinical and Utilization Review ensures management of limited resources, thereby maximizing the access to services provided to all Health Plan Members. Clinical and utilization review decisions are made using objective measurable review criteria that are based on reasonable medical evidence.

- Coverage determinations based on Clinical Review Criteria are made by qualified health professionals. Qualified health professionals who make clinical review decisions are not compensated nor are in receipt of financial incentives to encourage inappropriate decisions or denials of coverage for services. Clinical and utilization reviewers are not compensated for issuing specific denials of coverage or services.
- Qualified health professionals who make clinical and utilization review decisions are appropriately trained. The consistency of their review criteria application and decision-making is annually evaluated.
- Clinical review criteria are based on reasonable medical evidence and applied consistently throughout Group Health to assure uniform access to benefits for members. Clinical review criteria are developed by actively practicing, appropriate practitioners.
- Clinical review decisions are made taking into consideration the individual needs of the member and the local delivery system capabilities to provide the care needed.
- Health plan members are informed of coverage determinations in a timely manner to accommodate the clinical urgency of the situation.
- Health plan members are informed in writing of their appeal rights and responsibilities regarding non-covered services and how to obtain a copy of the criteria, the coverage language, or other information used in the denial determination.
- Practitioners are informed of and have access to the clinical review criteria. Practitioners also have the right to request an appeal of a denial on behalf of their patients.
- In addition to the above, services received in acute care settings are reviewed to:
    - identify the patient's coordination of care needs

  - establish length of stay targets
  - monitor variation from clinical pathways or guidelines
- Coverage that has been previously approved for an active Health Plan member is not retrospectively denied.

Clinical and Utilization Review	Policy Number: UM102
	Adopted: 1995
	Review Dates: 7/1998, 10/1998, 11/1999, 6/30/2000, 9/6/2001, 9/26/2002, 9/25/2003, 9/28/2004
	Revised: 7/1998, 10/1998, 11/1999, 6/30/2000, 9/6/2001, 9/26/2002, 9/25/2003, 9/28/2004

PROCEDURE

For Implementing Policy UM 102

Note: These procedures provide additional information related to Policy UM 102, but are separate and distinct from that policy. Group Health Cooperative management retains discretion in implementing these procedures and can change them at any time, with or without notice.

APPLICABILITY:

All requests for coverage of services listed in the Group Health Clinical Review Criteria and coverage for all services that Health Plan Members (Group Health Cooperative and Group Health Options, Inc.) and patients receive, or are proposed to receive, may be subject to review.

Reviews may be conducted on a pre-service, concurrently or post-service basis. Once a service has been reviewed, ongoing reviews may be conducted to identify coordination of care needs, variation from guidelines, and the need for ongoing care.

Group Health provides care to patients in its owned and operated facilities who are covered by other health insurance carriers. Appropriate utilization management staff will evaluate and apply the appropriate review criteria designated by the health carrier. Group Health Utilization Management Nurses facilitate such reviews by providing the health plan with information necessary for review. Review nurses provide the applicable health plan criteria to Group Health physicians upon request.

RESPONSIBILITIES:

First level review:
First level reviews are performed or overseen by appropriate clinical staff using Group Health approved clinical review criteria. Data sources for the review include, but are not limited to, referral forms, admission request forms, the patient medical record, consultation with the attending/referring physician and multidisciplinary health care team members. The clinical information used in the review may include treatment summaries, problem lists, specialty evaluations, laboratory and x-ray results, and rehabilitation service documentation. When applying the clinical criteria the following individual patient factors, when applicable, are considered: age, comorbidities, complications, progress of treatment, psychosocial situation, home environment. In addition the availability of the following local delivery system services and availability of coverage benefits for these services are considered: skilled nursing facilities, subacute care facilities and home care. Also considered is the ability of the local hospital to provide all the recommended services within the estimated length of stay. Individual case discussions are initiated when indicated by the patient or local system characteristics. The information used is limited to that needed to address the service request under review for coverage. The patient or legal surrogate may be contacted for information. Coordination of care interventions are initiated as they are identified. The reviewer may consult with a Board-certified consultative specialist and such consultations will be documented in the review test. If the requested service appears to be inappropriate based on application of the review criteria, the 1st level reviewer requests second level review by a physician or designated health care professional.

Second level (practitioner) review:
The practitioner reviews the treatment plan and discusses, when appropriate, case circumstances and management options with the attending (or referring) physician. The reviewer may consult with board certified physicians from appropriate specialty areas to assist in making determinations of coverage and/or appropriateness. All such consultations will be documented in the review test. If the reviewer determines that the admission, continued stay or service requested is not a covered service, a notice of non-coverage is issued.

Member and Practitioner Appeals:
Health Plan Members may appeal a denial of coverage as provided in the applicable health plan's policies regarding consumer complaints and appeals. Likewise, practitioners may appeal a notice of non-coverage consistent with the applicable health plan's appeal policies. Appeal instructions for members and practitioners are contained in the notice of non-coverage.

Reinstatement Of Coverage:
When the Health Plan Member's medical care needs change to the degree that he or she requires medically necessary care, after he or she has received a notice of non-coverage, medical coverage will be reinstated through the process of recertification. Coverage will begin on the date the member's condition again meets clinical review criteria.

DEFINITIONS:

Care Management Nurse: A registered nurse employed by or under contract with Group Health Cooperative who is responsible for review of the patient's medical record and treatment plan and coordination of patient care. Job titles for care management nurses are Care Manager (CM), Care Management Liaison Nurse (CMLN), and Hospital Liaison Nurse (HLN).

Clinical Review: The coverage review that applies a predefined set of objective, measurable

clinical review criteria.

Clinical Review Staff: Those persons employed by or under contract with Group Health, such as addictionologists, nurses, pharmacists, psychologists or other qualified health professional who are responsible for reviewing requests for coverage using clinical information and the Group Health approved clinical review criteria.

Health Plan Member: A person who, individually or as a part of a group, has entered into a contractual arrangement, or on whose behalf a contractual arrangement has been entered into with Group Health Cooperative and Group Health Options, Inc. to receive health care services; and enrollees of health maintenance organizations having a reciprocity agreement with Group Health (also referred to as "enrollee participant"); and subscribers of health plans who have contractually delegated utilization management and/or utilization management functions to Group Health. "Health Plan Member" includes, but is not limited to, all eligible Medicare beneficiaries.

Patient: A person receiving care or treatment; especially a person under the care of a practitioner.

Practitioner Reviewer: A physician, behavioral health practitioner (such as a psychiatrist, doctoral-level clinical psychologist, certified addiction medicine specialist) dentist, or pharmacist who have the clinical expertise appropriate to the request under review and to whom the Health Plan Medical Director or his/her designee has delegated responsibility for assuring that patient care meets professionally recognized standards and criteria for clinical indications and appropriateness.

Specialty Consultant to Utilization Management: A specialist certified by one of the American Boards of Medical Specialties who has been identified by a Group Health Medical Director as a consultant in clinical review determinations.

Utilization Review: The activity of conducting clinical reviews in a hospital/Skilled Nursing Facility/Home Health setting to ensure the patient continues to require the current level of care or can safely be transferred to another level of care.

Utilization Review Nurse: A registered nurse employed by the Health Plan who conducts clinical reviews in a hospital/Skilled Nursing Facility setting and forwards cases not meeting clinical review criteria to the appropriate 2nd level reviewer.

RELATED POLICIES AND DOCUMENTS

CMS OPL #71
CMS Grijalva Fast Track Process
NCQA 2004 UM 2, 4, 5, 6, 7, 14
Issuance of Notice of Non Coverage Policy UM106
Quality of Service - Consumer Complaints and Appeals Policy
Practitioner Appeals/Reconsiderations UM 109
Medical Technology Assessment Process, 1998
Group Health Cooperative Clinical Review Criteria
Utilization Management Specialty Consultant Roles and Responsibilities Policy UM104
CMS Managed Care Manual Chapter 13 and Monitoring Guide

GUIDELINES:

Time Standards for Coverage Determinations

Type of Review	GHC Standard
Hospital/SNF Admit and Concurrent Review – Initial Determination	• As expeditiously as the patient's health requires and • No greater than 24 hours following receipt of the request for coverage of service/referral
Hospital/SNF Admit and Concurrent Review – Reconsideration	• Within same day as the request for reconsideration
Pre–service review – Inpatient and Outpatient Service/Care	• Within 2 working days following receipt of all clinical information required to conduct a review or as expeditiously as the patient's health requires and • No greater than 12 calendar days following receipt of the request for service/referral • When expedited, not to exceed 72 hours after receipt
Pre–service review – Inpatient and Outpatient Service/Care – Urgent/Emergent	• Within 72 hours of receipt of the request or as expeditiously as the patient's health requires
Investigational/Experimental Service Request – Initial Determination	• Within 20 calendar days (non-medicare) and 12 calendar days (Medicare) of referral request and • When expedited, not to exceed 72 hours after receipt
Post–service Review Determination – Inpatient and Outpatient Service	• Within 28 calendar days following receipt of the request
Reconsiderations/Practitioner or Provider Appeals	• 5 working days

Standards for acute care review (hospital/skilled nursing facility/home health):

Purpose:

- identify coordination of care needs
- evaluate appropriateness for level of care
- establish length of stay targets
- monitor variation from clinical pathways or guidelines
- certify coverage for acute care treatment
- monitor appropriateness for continued care in the current setting

Type of Review	Standard
Admission Review	Initiate within 24 hours of admission or first workday following admission.

For Continued Stay Review: **Scope:** Reviews are focused on high-risk diagnoses, variation from clinical pathway or length of stay guidelines. Diagnoses are selected by delivery system utilization management oversight groups for a focused study.	**Frequency:** As necessary based on clinical data.
On-site review services at facilities include: Review staff are assigned to designated hospitals in the Health Plan Delivery System. They are responsible for monitoring utilization and assisting the hospital staff in transitioning the members into other settings of care and home.	• Guidelines for identification of Group Health staff at the facility, in accordance with facility procedures and contract • A process is established for scheduling the on–site review in advance, unless otherwise agreed upon • A process is established for ensuring that Group Health staff follow facility rules

PROCEDURE:

Each review site will establish a desk procedure that is consistent with this policy and procedure.

Documentation of Denials Must Include:

Denial File Content	Form or format
Activity dates: receipt, order of medical records, receipt of medical record, date review is completed	Printout of Electronic documentation of the review that includes necessary dates
Documentation of clinical records used for the review	Copies of the medical records
Document Clinical criteria and coverage reference used	Either printouts or inclusion of reference in electronic document
Documentation that board-certified specialist was consulted, when same or similar specialty is needed for consultation on the coverage determination	Printout of Electronic documentation of review
Documentation of the determination and rationale signed by the reviewer	Printout of Electronic documentation of review signed by the reviewer making the determination
Provider and consumer notified of appeals rights and rationale for determination	Copy of the signed letters sent that includes this information If inpatient hospital or SNF denial the patient signed receipt must also be included in the documentation. If sent by registered mail, the signed receipt is included.

Provider given explanation of how to contact the reviewer	Copy of signed letter sent that includes this information

For content questions contact: Candace Carroll.

Top of page | Utilization Management Home | Clinical Home | InContext Home | Clinical Search

Web Pages Revised: 12/3/2003
Technical problems to report? Contact the Web Author..

GroupHealth COOPERATIVE

Administration & Conference Center
521 Wall Street
Seattle, WA 98121-1536
www.ghc.org

October 20, 2005

James T. Odiorne, CPA, JD
Deputy Insurance Commissioner
Company Supervision Division
P.O. Box 40255
Olympia, WA 98504-0255

RE: Market Conduct Examination of Group Health Cooperative and Group Health Options, Inc.

Dear Deputy Commissioner Odiorne:

Thank you for the opportunity to respond to the updated General Examination Findings section of the market conduct examination report prepared for Group Health Cooperative and Group Health Options, Inc. (referred to collectively as "Group Health"). Per our agreement, this letter contains Group Health's comments on the General Examination Instruction and the related General Examination Findings. We provide these comments in addition to comments we previously sent on October 7, 2005 addressing the other instructions and recommendations in the market conduct examination.

We offer the following comments regarding Instruction number 1 and the related General Examination Findings:

1. **The Companies are instructed to provide their accounts, records, documents, and files to the examiners upon request. Reference: RCW 48.44.145(2), RCW 48.46.120(2).**

   As required by the referenced statutes, Group Health submitted its books and records relating to the market conduct examination in a timely fashion and worked diligently to facilitate the examination process.

   Timely Submissions: At the beginning of the examination process in June 2004, the examiners acknowledged the complexity of the information required by some of the requests and indicated a willingness to work with Group Health to grant extensions when it was not possible to meet the original due date for legitimate reasons. Group Health made every effort to meet the original due dates and only requested extensions when necessary. We appreciated the responsiveness of the examination staff when Group Health made those requests.

We also acknowledge and appreciate your office's effort to revise its draft of this finding, as your office has reviewed Group Health documentation demonstrating Group Health's timeliness. However, the General Examination Findings still indicate that several files were late, whereas Group Health records demonstrate that the files were submitted in a timely fashion. As demonstrated in documents provided to the examiners, Group Health obtained an extension and then submitted the material prior to the approved deadline with respect to request #038CFW. In connection with request # 034SR, the OIC office was closed when staff attempted delivery of the response between 4:00 and 5:00 pm on the afternoon of the due date. On another occasion (#035SR), the due date fell on a federal holiday, and Group Health staff attempted to deliver the response on the following business day between 4:00 and 5:00 pm. Once again, the OIC office appeared to be closed when the delivery was attempted. Finally, in connection with one complex request for follow-up information (request #024CFWNB), Group Health staff first obtained an extension via e-mail from the examiner, and then obtained approval by phone from the examiner that Group Health would be permitted to provide the information as it became available, due to the breadth and complexity of the follow-up information being sought.

In each of these instances, Group Health reasonably concluded that it was meeting the examiners' expectations on deadlines and was not hampering the progress of the examination.

Documentation Control: We respectfully disagree with the statement that Group Health has demonstrated a lack of control over documentation that could lead to release of confidential information. The OIC bases this concern on Group Health's inclusion of some original file documentation within the rating and underwriting files hand-delivered to OIC offices. Group Health staff involved in the market conduct review personally delivered these documents to OIC staff conducting the review of these files; these same Group Health staff members picked up these files directly from the OIC examination staff after the document review was complete. No confidential information was ever released to third parties. Group Health believes that the chain of control of the documents was adequate to safeguard against the potential inadvertent release of confidential business information.

Misunderstood Requests: Group Health is puzzled by the statement that "when requested materials were not provided, the Companies indicated that the requests were misunderstood. Attempts to contact the examiners regarding any confusion were not initiated." In reality, Group Health staff sought clarification when an examination request was not clear. Moreover, when Group Health learned that a response was incomplete, Group Health apologized, explained its error, and promptly produced the requested information.

Group Health takes regulatory examinations very seriously and works diligently to meet the expectations and needs of the examination team. In this examination, Group Health regularly engaged the examination team leadership in discussions about how best to meet the examination team's needs to facilitate the examination process. Group Health staff also participated in periodic meetings with the examiners in an effort to received feedback from the OIC about the

progress of the audit. A review of the facts of the market conduct examination demonstrates that Group Health met the legal standards articulated in RCW 48.44.145(2) and RCW 48.46.120(2).

Thank you for the opportunity to review and respond to this instruction. Please feel free to contact me if you have questions.

Sincerely,

Maureen McLaughlin
Executive Vice President, Health Plan Division, Group Health Cooperative
President and CEO, Group Health Options, Inc.

CC: Scott Plack, Director of Regulatory Affairs, Group Health Cooperative
Leslie Krier, Chief Market Conduct Examiner, Office of the Insurance Commissioner (via electronic mail)
Nancy Campbell, Market Conduct Examiner, Office of the Insurance Commissioner (via electronic mail)